

AMENDED IN SENATE MARCH 21, 2013

AMENDED IN SENATE MARCH 7, 2013

CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL

No. 2

Introduced by Assembly Member Pan

January 29, 2013

An act to amend Sections 10119.1, 10198.7, 10603, *10753*, 10753.05, 10753.06.5, 10753.11, 10753.12, 10753.14, and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to amend and add Sections 10113.95 and 10119.2 of, to add Sections 10127.21 and 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of Division 2 of, and to repeal Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as amended, Pan. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charged by a health insurance issuer

offering small group or individual coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family and prohibits discrimination against individuals based on health status, as specified. PPACA requires an issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool, as specified. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

Existing law provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements. Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would require an insurer, on and after October 1, 2013, to offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services, as specified, but would require insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these ~~health benefit plans~~ *insurers* from imposing any preexisting condition exclusion upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified. The bill would require a health insurer to consider the claims experience of all insureds of its nongrandfathered individual health benefit plans offered in the state to be part of a single risk pool, as specified, would require the insurer to establish a specified index rate for that market, and would authorize the insurer to vary premiums from the index rate based only on specified factors. The bill would authorize insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans, as specified. The bill would require insurers to provide specified information regarding the Exchange to applicants for and subscribers of individual health benefit plans offered outside the Exchange. The bill would prohibit an insurer from advertising or marketing an individual grandfathered health plan for

the purpose of enrolling a dependent of the policyholder in the plan and would also require insurers to annually issue a specified notice to policyholders enrolled in a grandfathered plan. The bill would make certain of these provisions inoperative if, and 12 months after, certain provisions of PPACA are repealed or amended, as specified.

Existing law requires insurers to guarantee issue their small employer health benefit plans, as specified. With respect to nongrandfathered small employer health benefit plans for plan years on or after January 1, 2014, among other things, existing law provides certain exceptions from the guarantee issue requirement, allows the premium for small employer health benefit plans to vary only by age, geographic region, and family size, as specified, and requires insurers to provide special enrollment periods and coverage effective dates consistent with the individual nongrandfathered market in the state. Existing law provides that these provisions shall be inoperative if specified provisions of PPACA are repealed.

This bill would modify the small employer special enrollment periods and coverage effective dates for purposes of consistency with the individual market reforms described above. The bill would also modify the exceptions from the guarantee issue requirement and the manner in which an insurer determines premium rates for a small employer health benefit plan, as specified. The bill would also require an insurer to consider the claims experience of all enrollees of its nongrandfathered small employer health benefit plans offered in this state to be part of a single risk pool, as specified, would require the insurer to establish a specified index rate for that market, and would authorize the insurer to vary premiums from the index rate based only on specified factors. The bill would make certain of these provisions inoperative, as specified, if, and 12 months after specified provisions of PPACA are repealed.

(2) PPACA requires a state or the United States Secretary of Health and Human Services to implement a risk adjustment program for the 2014 benefit year and every benefit year thereafter, under which a charge is assessed on low actuarial risk plans and a payment is made to high actuarial risk plans, as specified. If a state that elects to operate an American Health Benefit Exchange elects not to administer this risk adjustment program, the secretary will operate the program and issuers will be required to submit data for purposes of the program to the secretary.

This bill would require that any data submitted by health insurers to the secretary for purposes of the risk adjustment program also be

submitted to the Department of Insurance, in the same format. The bill would require the department to use that data for specified purposes.

(3) Existing law requires insurers to provide a summary of information about each of their health insurance policies, as provided, upon the appropriate disclosure form as prescribed by the Insurance Commissioner.

This bill would provide that, on and after January 1, 2014, a health insurer issuing the federal uniform summary of benefits and coverage also complies with the commissioner’s disclosure requirements, but would require that the insurer ensure that all applicable state law disclosures are made in other documents. The bill would require the insurer to provide the commissioner a copy of the federal summary of benefits and coverage form and the corresponding health insurance policy, as specified.

(4) This bill would become operative only if ~~S.B.~~ SB 2 of the 2013–14 First Extraordinary Session is enacted and becomes effective.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 10113.95 of the Insurance Code is
2 amended to read:

3 10113.95. (a) A health insurer that issues, renews, or amends
4 individual health insurance policies shall be subject to this section.

5 (b) An insurer subject to this section shall have written policies,
6 procedures, or underwriting guidelines establishing the criteria
7 and process whereby the insurer makes its decision to provide or
8 to deny coverage to individuals applying for coverage and sets the
9 rate for that coverage. These guidelines, policies, or procedures
10 shall ensure that the plan rating and underwriting criteria comply
11 with Sections 10140 and 10291.5 and all other applicable
12 provisions.

13 (c) On or before June 1, 2006, and annually thereafter, every
14 insurer shall file with the commissioner a general description of
15 the criteria, policies, procedures, or guidelines that the insurer uses
16 for rating and underwriting decisions related to individual health
17 insurance policies, which means automatic declinable health
18 conditions, health conditions that may lead to a coverage decline,
19 height and weight standards, health history, health care utilization,

1 lifestyle, or behavior that might result in a decline for coverage or
2 severely limit the health insurance products for which individuals
3 applying for coverage would be eligible. An insurer may comply
4 with this section by submitting to the department underwriting
5 materials or resource guides provided to agents and brokers,
6 provided that those materials include the information required to
7 be submitted by this section.

8 (d) Commencing January 1, 2011, the commissioner shall post
9 on the department’s Internet Web site, in a manner accessible and
10 understandable to consumers, general, noncompany specific
11 information about rating and underwriting criteria and practices
12 in the individual market and information about the California Major
13 Risk Medical Insurance Program (Part 6.5 (commencing with
14 Section 12700)) and the federal temporary high risk pool
15 established pursuant to Part 6.6 (commencing with Section
16 12739.5). The commissioner shall develop the information for the
17 Internet Web site in consultation with the Department of Managed
18 Health Care to enhance the consistency of information provided
19 to consumers. Information about individual health insurance shall
20 also include the following notification:

21
22 “Please examine your options carefully before declining group
23 coverage or continuation coverage, such as COBRA, that may be
24 available to you. You should be aware that companies selling
25 individual health insurance typically require a review of your
26 medical history that could result in a higher premium or you could
27 be denied coverage entirely.”

28
29 (e) Nothing in this section shall authorize public disclosure of
30 company-specific rating and underwriting criteria and practices
31 submitted to the commissioner.

32 (f) This section shall not apply to a closed block of business, as
33 defined in Section 10176.10.

34 (g) (1) This section shall become inoperative on November 1,
35 2013, or the 91st calendar day following the adjournment of the
36 2013–14 First Extraordinary Session, whichever date is later.

37 (2) If Section 5000A of the Internal Revenue Code, as added
38 by Section 1501 of PPACA, is repealed or amended to no longer
39 apply to the individual market, as defined in Section 2791 of the
40 federal Public Health–~~Services~~ *Service* Act (42 U.S.C. Sec.

1 300gg-4), this section shall become operative 12 months after the
2 date of that repeal or amendment.

3 SEC. 2. Section 10113.95 is added to the Insurance Code, to
4 read:

5 10113.95. (a) A health insurer that renews individual
6 grandfathered health benefit plans shall be subject to this section.

7 (b) An insurer subject to this section shall have written policies,
8 procedures, or underwriting guidelines establishing the criteria
9 and process whereby the insurer makes its decision to provide or
10 to deny coverage to dependents applying for an individual
11 grandfathered health benefit plan and sets the rate for that coverage.
12 These guidelines, policies, or procedures shall ensure that the plan
13 rating and underwriting criteria comply with Sections 10140 and
14 10291.5 and all other applicable provisions of state and federal
15 law.

16 (c) On or before the June 1 next following the operative date of
17 this section, and annually thereafter, every insurer shall file with
18 the commissioner a general description of the criteria, policies,
19 procedures, or guidelines that the insurer uses for rating and
20 underwriting decisions related to individual grandfathered health
21 benefit plans, which means automatic declinable health conditions,
22 health conditions that may lead to a coverage decline, height and
23 weight standards, health history, health care utilization, lifestyle,
24 or behavior that might result in a decline for coverage or severely
25 limit the health insurance products for which individuals applying
26 for coverage would be eligible. An insurer may comply with this
27 section by submitting to the department underwriting materials or
28 resource guides provided to agents and brokers, provided that those
29 materials include the information required to be submitted by this
30 section.

31 (d) Nothing in this section shall authorize public disclosure of
32 company-specific rating and underwriting criteria and practices
33 submitted to the commissioner.

34 (e) For purposes of this section, the following definitions shall
35 apply:

36 (1) "PPACA" means the federal Patient Protection and
37 Affordable Care Act (Public Law 111-148), as amended by the
38 federal Health Care and Education Reconciliation Act of 2010
39 (Public Law 111-152), and any rules, regulations, or guidance
40 issued pursuant to that law.

1 (2) “Grandfathered health benefit plan” has the same meaning
2 as that term is defined in Section 1251 of PPACA.

3 (f) (1) This section shall become operative on November 1,
4 2013, or the 91st calendar day following the adjournment of the
5 2013–14 First Extraordinary Session, whichever date is later.

6 (2) If Section 5000A of the Internal Revenue Code, as added
7 by Section 1501 of PPACA, is repealed or amended to no longer
8 apply to the ~~individual~~ *individual* market, as defined in Section
9 2791 of the federal Public Health ~~Services Service~~ Act (42 U.S.C.
10 Sec. 300gg-4), this section shall become inoperative 12 months
11 after the date of that repeal or amendment.

12 SEC. 3. Section 10119.1 of the Insurance Code is amended to
13 read:

14 10119.1. (a) This section shall apply to a health insurer that
15 covers hospital, medical, or surgical expenses under an individual
16 health benefit plan, as defined in subdivision (a) of Section
17 10198.6, that is issued, amended, renewed, or delivered on or after
18 January 1, 2007.

19 (b) At least once each year, a health insurer shall permit an
20 individual who has been covered for at least 18 months under an
21 individual health benefit plan to transfer, without medical
22 underwriting, to any other individual health benefit plan offered
23 by that same health insurer that provides equal or lesser benefits
24 as determined by the insurer.

25 “Without medical underwriting” means that the health insurer
26 shall not decline to offer coverage to, or deny enrollment of, the
27 individual or impose any preexisting condition exclusion on the
28 individual who transfers to another individual health benefit plan
29 pursuant to this section.

30 (c) The insurer shall establish, for the purposes of subdivision
31 (b), a ranking of the individual health benefit plans it offers to
32 individual purchasers and post the ranking on its Internet Web site
33 or make the ranking available upon request. The insurer shall
34 update the ranking whenever a new benefit design for individual
35 purchasers is approved.

36 (d) The insurer shall notify in writing all insureds of the right
37 to transfer to another individual health benefit plan pursuant to
38 this section, at a minimum, when the insurer changes the insured’s
39 premium rate. Posting this information on the insurer’s Internet
40 Web site shall not constitute notice for purposes of this subdivision.

1 The notice shall adequately inform insureds of the transfer rights
2 provided under this section including information on the process
3 to obtain details about the individual health benefit plans available
4 to that insured and advising that the insured may be unable to
5 return to his or her current individual health benefit plan if the
6 insured transfers to another individual health benefit plan.

7 (e) The requirements of this section shall not apply to the
8 following:

9 (1) A federally eligible defined individual, as defined in
10 subdivision (e) of Section 10900, who purchases individual
11 coverage pursuant to Section 10785.

12 (2) An individual offered conversion coverage pursuant to
13 Sections 12672 and 12682.1.

14 (3) An individual enrolled in the Medi-Cal program pursuant
15 to Chapter 7 (commencing with Section 14000) of Part 3 of
16 Division 9 of the Welfare and Institutions Code.

17 (4) An individual enrolled in the Access for Infants and Mothers
18 Program, pursuant to Part 6.3 (commencing with Section 12695).

19 (5) An individual enrolled in the Healthy Families Program
20 pursuant to Part 6.2 (commencing with Section 12693).

21 (f) It is the intent of the Legislature that individuals shall have
22 more choice in their health care coverage when health insurers
23 guarantee the right of an individual to transfer to another product
24 based on the insurer's own ranking system. The Legislature does
25 not intend for the department to review or verify the insurer's
26 ranking for actuarial or other purposes.

27 (g) (1) This section shall become inoperative on January 1,
28 2014, or the 91st calendar day following the adjournment of the
29 2013–14 First Extraordinary Session, whichever date is later.

30 (2) If Section 5000A of the Internal Revenue Code, as added
31 by Section 1501 of PPACA, is repealed or amended to no longer
32 apply to the individual market, as defined in Section 2791 of the
33 federal Public Health—~~Services~~ *Service* Act (42 U.S.C. Sec.
34 300gg-4), this section shall become operative 12 months after the
35 date of that repeal or amendment.

36 SEC. 4. Section 10119.2 of the Insurance Code is amended to
37 read:

38 10119.2. (a) Every health insurer that offers, issues, or renews
39 health insurance under an individual health benefit plan, as defined
40 in subdivision (a) of Section 10198.6, shall offer to any individual,

1 who was covered under an individual health benefit plan that was
2 rescinded, a new individual health benefit plan without medical
3 underwriting that provides equal benefits. A health insurer may
4 also permit an individual, who was covered under an individual
5 health benefit plan that was rescinded, to remain covered under
6 that individual health benefit plan, with a revised premium rate
7 that reflects the number of persons remaining on the health benefit
8 plan.

9 (b) “Without medical underwriting” means that the health insurer
10 shall not decline to offer coverage to, or deny enrollment of, the
11 individual or impose any preexisting condition exclusion on the
12 individual who is issued a new individual health benefit plan or
13 remains covered under an individual health benefit plan pursuant
14 to this section.

15 (c) If a new individual health benefit plan is issued, the insurer
16 may revise the premium rate to reflect only the number of persons
17 covered under the new individual health benefit plan.

18 (d) Notwithstanding subdivisions (a) and (b), if an individual
19 was subject to a preexisting condition provision or a waiting or
20 affiliation period under the individual health benefit plan that was
21 rescinded, the health insurer may apply the same preexisting
22 condition provision or waiting or affiliation period in the new
23 individual health benefit plan. The time period in the new
24 individual health benefit plan for the preexisting condition
25 provision or waiting or affiliation period shall not be longer than
26 the one in the individual health benefit plan that was rescinded
27 and the health insurer shall credit any time that the individual was
28 covered under the rescinded individual health benefit plan.

29 (e) The insurer shall notify in writing all insureds of the right
30 to coverage under an individual health benefit plan pursuant to
31 this section, at a minimum, when the insurer rescinds the individual
32 health benefit plan. The notice shall adequately inform insureds
33 of the right to coverage provided under this section.

34 (f) The insurer shall provide 60 days for insureds to accept the
35 offered new individual health benefit plan and this plan shall be
36 effective as of the effective date of the original individual health
37 benefit plan and there shall be no lapse in coverage.

38 (g) This section shall not apply to any individual whose
39 information in the application for coverage and related
40 communications led to the rescission.

1 (h) (1) This section shall become inoperative on January 1,
2 2014, or the 91st calendar day following the adjournment of the
3 2013–14 First Extraordinary Session, whichever date is later.

4 (2) If Section 5000A of the Internal Revenue Code, as added
5 by Section 1501 of PPACA, is repealed or amended to no longer
6 apply to the individual market, as defined in Section 2791 of the
7 federal Public Health—~~Services~~ *Service* Act (42 U.S.C. Sec.
8 300gg-4), this section shall become operative 12 months after the
9 date of that repeal or amendment.

10 SEC. 5. Section 10119.2 is added to the Insurance Code, to
11 read:

12 10119.2. (a) Every health insurer that offers, issues, or renews
13 health insurance under an individual health benefit plan, as defined
14 in subdivision (a) of Section ~~10198.6, through the California Health~~
15 ~~Benefit Exchange~~ *10198.6*, shall offer to any individual, who was
16 covered by the insurer under an individual health benefit plan that
17 was rescinded, a new individual health benefit plan ~~through the~~
18 ~~Exchange~~ that provides the most equivalent benefits.

19 (b) A health insurer that offers, issues, or renews individual
20 health benefit plans inside or outside the California Health Benefit
21 Exchange may also permit an individual, who was covered by the
22 insurer under an individual health benefit plan that was rescinded,
23 to remain covered under that individual health benefit plan, with
24 a revised premium rate that reflects the number of persons
25 remaining on the health benefit plan consistent with Section
26 10965.9.

27 (c) If a new individual health benefit plan is issued under
28 subdivision (a), the insurer may revise the premium rate to reflect
29 only the number of persons covered on the new individual health
30 benefit plan consistent with Section 10965.9.

31 (d) The insurer shall notify in writing all insureds of the right
32 to coverage under an individual health benefit plan pursuant to
33 this section, at a minimum, when the insurer rescinds the individual
34 health benefit plan. The notice shall adequately inform insureds
35 of the right to coverage provided under this section.

36 (e) The insurer shall provide 60 days for insureds to accept the
37 offered new individual health benefit plan under subdivision (a),
38 and this plan shall be effective as of the effective date of the
39 original health benefit plan and there shall be no lapse in coverage.

1 (f) This section shall not apply to any individual whose
2 information in the application for coverage and related
3 communications led to the rescission.

4 (g) This section shall apply notwithstanding subdivision (a) or
5 (d) of Section 10965.3.

6 (h) (1) This section shall become operative on January 1, 2014,
7 or the 91st calendar day following the adjournment of the 2013–14
8 First Extraordinary Session, whichever date is later.

9 (2) If Section 5000A of the Internal Revenue Code, as added
10 by Section 1501 of PPACA, is repealed or amended to no longer
11 apply to the individual market, as defined in Section 2791 of the
12 federal Public Health–Services Service Act (42 U.S.C. Sec.
13 300gg-4), this section shall become inoperative 12 months after
14 the date of that repeal or amendment.

15 SEC. 6. Section 10127.21 is added to the Insurance Code, to
16 read:

17 10127.21. Any data submitted by a health insurer to the United
18 States Secretary of Health and Human Services, or his or her
19 designee, for purposes of the risk adjustment program described
20 in Section 1343 of the federal Patient Protection and Affordable
21 Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted
22 to the department and in the same format. The department shall
23 use the information to monitor federal implementation of risk
24 adjustment in the state and to ensure that insurers are in compliance
25 with federal requirements related to risk adjustment.

26 SEC. 7. Section 10198.7 of the Insurance Code is amended to
27 read:

28 10198.7. (a) A health benefit plan for group coverage shall
29 not impose any preexisting condition provision or waived
30 condition provision upon any individual.

31 (b) (1) A nongrandfathered health benefit plan for individual
32 coverage shall not impose any preexisting condition provision or
33 waived condition provision upon any individual. ~~A grandfathered~~
34 ~~health benefit plan for individual coverage shall not exclude~~
35 ~~coverage on the basis of a waived condition provision or~~
36 ~~preexisting condition provision for a period greater than 12 months~~
37 ~~following the individual's effective date of coverage, nor limit or~~
38 ~~exclude coverage for a specific insured by type of illness, treatment,~~
39 ~~medical condition, or accident, except for satisfaction of a~~
40 ~~preexisting condition provision or waived condition provision~~

~~1 pursuant to this article. Waivered condition provisions or
2 preexisting condition provisions contained in health benefit plans
3 may relate only to conditions for which medical advice, diagnosis,
4 care, or treatment, including use of prescription drugs, was
5 recommended or received from a licensed health practitioner during
6 the 12 months immediately preceding the effective date of
7 coverage.~~

8 *(2) A grandfathered health benefit plan for individual coverage
9 shall not exclude coverage on the basis of a waived condition
10 provision or preexisting condition provision for a period greater
11 than 12 months following the individual's effective date of
12 coverage, nor limit or exclude coverage for a specific insured by
13 type of illness, treatment, medical condition, or accident, except
14 for satisfaction of a preexisting condition provision or waived
15 condition provision pursuant to this article. Waivered condition
16 provisions or preexisting condition provisions contained in
17 individual grandfathered health benefit plans may relate only to
18 conditions for which medical advice, diagnosis, care, or treatment,
19 including use of prescription drugs, was recommended or received
20 from a licensed health practitioner during the 12 months
21 immediately preceding the effective date of coverage.*

22 *(3) If Section 5000A of the Internal Revenue Code, as added by
23 Section 1501 of PPACA, is repealed or amended to no longer apply
24 to the individual market, as defined in Section 2791 of the Public
25 Health Service Act (42 U.S.C. Sec. 300gg-4), paragraph (1) shall
26 become inoperative 12 months after the date of that repeal or
27 amendment and thereafter paragraph (2) shall apply also to
28 nongrandfathered health benefit plans for individual coverage.*

29 (c) (1) A health benefit plan for group coverage may apply a
30 waiting period of up to 60 days as a condition of employment if
31 applied equally to all eligible employees and dependents and if
32 consistent with PPACA. A waiting period shall not be based on a
33 preexisting condition of an employee or dependent, the health
34 status of an employee or dependent, or any other factor listed in
35 Section 10198.9. During the waiting period, the health benefit plan
36 is not required to provide health care services and no premium
37 shall be charged to the policyholder or insureds.

38 (2) A health benefit plan for individual coverage shall not
39 impose a waiting period.

1 (d) In determining whether a preexisting condition provision,
2 a waived condition provision, or a waiting period applies to a
3 person, a health benefit plan shall credit the time the person was
4 covered under creditable coverage, provided that the person
5 becomes eligible for coverage under the succeeding health benefit
6 plan within 62 days of termination of prior coverage, exclusive of
7 any waiting period, and applies for coverage under the succeeding
8 plan within the applicable enrollment period. A plan shall also
9 credit any time that an eligible employee must wait before enrolling
10 in the plan, including any postenrollment or employer-imposed
11 waiting period. ~~However, if a person's employment has ended, the~~
12 ~~availability of health coverage offered through employment or~~
13 ~~sponsored by an employer has terminated, or an employer's~~
14 ~~contribution toward health coverage has terminated, a carrier shall~~
15 ~~credit the time the person was covered under creditable coverage~~
16 ~~if the person becomes eligible for health coverage offered through~~
17 ~~employment or sponsored by an employer within 180 days,~~
18 ~~exclusive of any waiting period, and applies for coverage under~~
19 ~~the succeeding plan within the applicable enrollment period.~~

20 *However, if a person's employment has ended, the availability*
21 *of health coverage offered through employment or sponsored by*
22 *an employer has terminated, or an employer's contribution toward*
23 *health coverage has terminated, a carrier shall credit the time the*
24 *person was covered under creditable coverage if the person*
25 *becomes eligible for health coverage offered through employment*
26 *or sponsored by an employer within 180 days, exclusive of any*
27 *waiting period, and applies for coverage under the succeeding*
28 *plan within the applicable enrollment period.*

29 (e) An individual's period of creditable coverage shall be
30 certified pursuant to Section 2704(e) of Title XXVII of the federal
31 Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

32 SEC. 8. Section 10603 of the Insurance Code is amended to
33 read:

34 10603. (a) (1) On or before April 1, 1975, the commissioner
35 shall promulgate a standard supplemental disclosure form for all
36 disability insurance policies. Upon the appropriate disclosure form
37 as prescribed by the commissioner, each insurer shall provide, in
38 easily understood language and in a uniform, clearly organized
39 manner, as prescribed and required by the commissioner, the
40 summary information about each disability insurance policy offered

1 by the insurer as the commissioner finds is necessary to provide
2 for full and fair disclosure of the provisions of the policy.

3 (2) On and after January 1, 2014, a disability insurer offering
4 health insurance coverage subject to Section 2715 of the federal
5 Public Health Service Act (42 U.S.C. Sec. 300gg-15) shall satisfy
6 the requirements of this section and the implementing regulations
7 by providing the uniform summary of benefits and coverage
8 required under Section 2715 of the federal Public Health Service
9 Act and any rules or regulations issued thereunder. An insurer that
10 issues the federal uniform summary of benefits referenced in this
11 paragraph shall ensure that all applicable disclosures required in
12 this chapter and its implementing regulations are met in other
13 documents provided to policyholders and insureds. An insurer
14 subject to this paragraph shall provide the uniform summary of
15 benefits and coverage to the commissioner together with the
16 corresponding health insurance policy pursuant to Section 10290.

17 (b) Nothing in this section shall preclude the disclosure form
18 from being included with the evidence of coverage or certificate
19 of coverage or policy.

20 *SEC. 9. Section 10753 of the Insurance Code is amended to*
21 *read:*

22 10753. (a) “Agent or broker” means a person or entity licensed
23 under Chapter 5 (commencing with Section 1621) of Part 2 of
24 Division 1.

25 (b) “Benefit plan design” means a specific health coverage
26 product issued by a carrier to small employers, to trustees of
27 associations that include small employers, or to individuals if the
28 coverage is offered through employment or sponsored by an
29 employer. It includes services covered and the levels of copayment
30 and deductibles, and it may include the professional providers who
31 are to provide those services and the sites where those services are
32 to be provided. A benefit plan design may also be an integrated
33 system for the financing and delivery of quality health care services
34 which has significant incentives for the covered individuals to use
35 the system.

36 (c) “Carrier” means a health insurer or any other entity that
37 writes, issues, or administers health benefit plans that cover the
38 employees of small employers, regardless of the situs of the
39 contract or master policyholder.

1 (d) “Child” means a child described in Section 22775 of the
2 Government Code and subdivisions (n) to (p), inclusive, of Section
3 599.500 of Title 2 of the California Code of Regulations.

4 (e) “Dependent” means the spouse or registered domestic
5 partner, or child, of an eligible employee, subject to applicable
6 terms of the health benefit plan covering the employee, and
7 includes dependents of guaranteed association members if the
8 association elects to include dependents under its health coverage
9 at the same time it determines its membership composition pursuant
10 to subdivision (s).

11 (f) “Eligible employee” means either of the following:

12 (1) Any permanent employee who is actively engaged on a
13 full-time basis in the conduct of the business of the small employer
14 with a normal workweek of an average of 30 hours per week over
15 the course of a month, in the small employer’s regular place of
16 business, who has met any statutorily authorized applicable waiting
17 period requirements. The term includes sole proprietors or partners
18 of a partnership, if they are actively engaged on a full-time basis
19 in the small employer’s business, and they are included as
20 employees under a health benefit plan of a small employer, but
21 does not include employees who work on a part-time, temporary,
22 or substitute basis. It includes any eligible employee, as defined
23 in this paragraph, who obtains coverage through a guaranteed
24 association. Employees of employers purchasing through a
25 guaranteed association shall be deemed to be eligible employees
26 if they would otherwise meet the definition except for the number
27 of persons employed by the employer. A permanent employee
28 who works at least 20 hours but not more than 29 hours is deemed
29 to be an eligible employee if all four of the following apply:

30 (A) The employee otherwise meets the definition of an eligible
31 employee except for the number of hours worked.

32 (B) The employer offers the employee health coverage under a
33 health benefit plan.

34 (C) All similarly situated individuals are offered coverage under
35 the health benefit plan.

36 (D) The employee must have worked at least 20 hours per
37 normal workweek for at least 50 percent of the weeks in the
38 previous calendar quarter. The insurer may request any necessary
39 information to document the hours and time period in question,

1 including, but not limited to, payroll records and employee wage
2 and tax filings.

3 (2) Any member of a guaranteed association as defined in
4 subdivision (s).

5 (g) “Enrollee” means an eligible employee or dependent who
6 receives health coverage through the program from a participating
7 carrier.

8 (h) “Exchange” means the California Health Benefit Exchange
9 created by Section 100500 of the Government Code.

10 (i) “Financially impaired” means, for the purposes of this
11 chapter, a carrier that, on or after the effective date of this chapter,
12 is not insolvent and is either:

13 (1) Deemed by the commissioner to be potentially unable to
14 fulfill its contractual obligations.

15 (2) Placed under an order of rehabilitation or conservation by
16 a court of competent jurisdiction.

17 (j) “Health benefit plan” means a policy of health insurance, as
18 defined in Section 106, for the covered eligible employees of a
19 small employer and their dependents. The term does not include
20 coverage of Medicare services pursuant to contracts with the United
21 States government, or coverage that provides excepted benefits,
22 as described in Sections 2722 and 2791 of the federal Public Health
23 Service Act, subject to Section 10701.

24 (k) “In force business” means an existing health benefit plan
25 issued by the carrier to a small employer.

26 (l) “Late enrollee” means an eligible employee or dependent
27 who has declined health coverage under a health benefit plan
28 offered by a small employer at the time of the initial enrollment
29 period provided under the terms of the health benefit plan
30 consistent with the periods provided pursuant to Section 10753.05
31 and who subsequently requests enrollment in a health benefit plan
32 of that small employer, except where the employee or dependent
33 qualifies for a special enrollment period provided pursuant to
34 Section 10753.05. It also means any member of an association that
35 is a guaranteed association as well as any other person eligible to
36 purchase through the guaranteed association when that person has
37 failed to purchase coverage during the initial enrollment period
38 provided under the terms of the guaranteed association’s health
39 benefit plan consistent with the periods provided pursuant to
40 Section 10753.05 and who subsequently requests enrollment in

1 the plan, except where the employee or dependent qualifies for a
2 special enrollment period provided pursuant to Section 10753.05.

3 (m) “New business” means a health benefit plan issued to a
4 small employer that is not the carrier’s in force business.

5 (n) “Preexisting condition provision” means a policy provision
6 that excludes coverage for charges or expenses incurred during a
7 specified period following the insured’s effective date of coverage,
8 as to a condition for which medical advice, diagnosis, care, or
9 treatment was recommended or received during a specified period
10 immediately preceding the effective date of coverage.

11 (o) “Creditable coverage” means:

12 (1) Any individual or group policy, contract, or program, that
13 is written or administered by a health insurer, health care service
14 plan, fraternal benefits society, self-insured employer plan, or any
15 other entity, in this state or elsewhere, and that arranges or provides
16 medical, hospital, and surgical coverage not designed to supplement
17 other private or governmental plans. The term includes continuation
18 or conversion coverage but does not include accident only, credit,
19 coverage for onsite medical clinics, disability income, Medicare
20 supplement, long-term care, dental, vision, coverage issued as a
21 supplement to liability insurance, insurance arising out of a
22 workers’ compensation or similar law, automobile medical payment
23 insurance, or insurance under which benefits are payable with or
24 without regard to fault and that is statutorily required to be
25 contained in any liability insurance policy or equivalent
26 self-insurance.

27 (2) The federal Medicare Program pursuant to Title XVIII of
28 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

29 (3) The Medicaid Program pursuant to Title XIX of the federal
30 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

31 (4) Any other publicly sponsored program, provided in this state
32 or elsewhere, of medical, hospital, and surgical care.

33 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
34 (Civilian Health and Medical Program of the Uniformed Services
35 (CHAMPUS)).

36 (6) A medical care program of the Indian Health Service or of
37 a tribal organization.

38 (7) A health plan offered under 5 U.S.C. Chapter 89
39 (commencing with Section 8901) (Federal Employees Health
40 Benefits Program (FEHBP)).

1 (8) A public health plan as defined in federal regulations
2 authorized by Section 2701(c)(1)(I) of the federal Public Health
3 Service Act, as amended by Public Law 104-191, the federal Health
4 Insurance Portability and Accountability Act of 1996.

5 (9) A health benefit plan under Section 5(e) of the federal Peace
6 Corps Act (22 U.S.C. Sec. 2504(e)).

7 (10) Any other creditable coverage as defined by subdivision
8 (c) of Section 2704 of Title XXVII of the federal Public Health
9 Service Act (42 U.S.C. Sec. 300gg-3(c)).

10 (p) “Rating period” means the period for which premium rates
11 established by a carrier are in effect and shall be no less than 12
12 months from the date of issuance or renewal of the health benefit
13 plan.

14 (q) (1) “Small employer” means either of the following:

15 (A) For plan years commencing on or after January 1, 2014,
16 and on or before December 31, 2015, any person, firm, proprietary
17 or nonprofit corporation, partnership, public agency, or association
18 that is actively engaged in business or service, that, on at least 50
19 percent of its working days during the preceding calendar quarter
20 or preceding calendar year, employed at least one, but no more
21 than 50, eligible employees, the majority of whom were employed
22 within this state, that was not formed primarily for purposes of
23 buying health benefit plans, and in which a bona fide
24 employer-employee relationship exists. For plan years commencing
25 on or after January 1, 2016, any person, firm, proprietary or
26 nonprofit corporation, partnership, public agency, or association
27 that is actively engaged in business or service, that, on at least 50
28 percent of its working days during the preceding calendar quarter
29 or preceding calendar year, employed at least one, but no more
30 than 100, eligible employees, the majority of whom were employed
31 within this state, that was not formed primarily for purposes of
32 buying health benefit plans, and in which a bona fide
33 employer-employee relationship exists. In determining whether
34 to apply the calendar quarter or calendar year test, a carrier shall
35 use the test that ensures eligibility if only one test would establish
36 eligibility. In determining the number of eligible employees,
37 companies that are affiliated companies and that are eligible to file
38 a combined tax return for purposes of state taxation shall be
39 considered one employer. Subsequent to the issuance of a health
40 benefit plan to a small employer pursuant to this chapter, and for

1 the purpose of determining eligibility, the size of a small employer
2 shall be determined annually. Except as otherwise specifically
3 provided in this chapter, provisions of this chapter that apply to a
4 small employer shall continue to apply until the plan contract
5 anniversary following the date the employer no longer meets the
6 requirements of this definition. It includes any small employer as
7 defined in this subparagraph who purchases coverage through a
8 guaranteed association, and any employer purchasing coverage
9 for employees through a guaranteed association. This subparagraph
10 shall be implemented to the extent consistent with PPACA, except
11 that the minimum requirement of one employee shall be
12 implemented only to the extent required by PPACA.

13 (B) Any guaranteed association, as defined in subdivision (r),
14 that purchases health coverage for members of the association.

15 (2) For plan years commencing on or after January 1, 2014, the
16 definition of an employer, for purposes of determining whether
17 an employer with one employee shall include sole proprietors,
18 certain owners of “S” corporations, or other individuals, shall be
19 consistent with Section 1304 of PPACA.

20 (r) “Guaranteed association” means a nonprofit organization
21 comprised of a group of individuals or employers who associate
22 based solely on participation in a specified profession or industry,
23 accepting for membership any individual or employer meeting its
24 membership criteria which (1) includes one or more small
25 employers as defined in subparagraph (A) of paragraph (1) of
26 subdivision (q), (2) does not condition membership directly or
27 indirectly on the health or claims history of any person, (3) uses
28 membership dues solely for and in consideration of the membership
29 and membership benefits, except that the amount of the dues shall
30 not depend on whether the member applies for or purchases
31 insurance offered by the association, (4) is organized and
32 maintained in good faith for purposes unrelated to insurance, (5)
33 has been in active existence on January 1, 1992, and for at least
34 five years prior to that date, (6) has been offering health insurance
35 to its members for at least five years prior to January 1, 1992, (7)
36 has a constitution and bylaws, or other analogous governing
37 documents that provide for election of the governing board of the
38 association by its members, (8) offers any benefit plan design that
39 is purchased to all individual members and employer members in
40 this state, (9) includes any member choosing to enroll in the benefit

1 plan design offered to the association provided that the member
2 has agreed to make the required premium payments, and (10)
3 covers at least 1,000 persons with the carrier with which it
4 contracts. The requirement of 1,000 persons may be met if
5 component chapters of a statewide association contracting
6 separately with the same carrier cover at least 1,000 persons in the
7 aggregate.

8 This subdivision applies regardless of whether a master policy
9 by an admitted insurer is delivered directly to the association or a
10 trust formed for or sponsored by an association to administer
11 benefits for association members.

12 For purposes of this subdivision, an association formed by a
13 merger of two or more associations after January 1, 1992, and
14 otherwise meeting the criteria of this subdivision shall be deemed
15 to have been in active existence on January 1, 1992, if its
16 predecessor organizations had been in active existence on January
17 1, 1992, and for at least five years prior to that date and otherwise
18 met the criteria of this subdivision.

19 (s) “Members of a guaranteed association” means any individual
20 or employer meeting the association’s membership criteria if that
21 person is a member of the association and chooses to purchase
22 health coverage through the association. At the association’s
23 discretion, it may also include employees of association members,
24 association staff, retired members, retired employees of members,
25 and surviving spouses and dependents of deceased members.
26 However, if an association chooses to include those persons as
27 members of the guaranteed association, the association must so
28 elect in advance of purchasing coverage from a plan. Health plans
29 may require an association to adhere to the membership
30 composition it selects for up to 12 months.

31 (t) “Grandfathered health plan” has the meaning set forth in
32 Section 1251 of PPACA.

33 (u) “Nongrandfathered health benefit plan” means a health
34 benefit plan that is not a grandfathered health plan.

35 (v) “Plan year” has the meaning set forth in Section 144.103 of
36 Title 45 of the Code of Federal Regulations.

37 (w) “PPACA” means the federal Patient Protection and
38 Affordable Care Act (Public Law 111-148), as amended by the
39 federal Health Care and Education Reconciliation Act of 2010

1 (Public Law 111-152), and any rules, regulations, or guidance
2 issued thereunder.

3 (x) “Waiting period” means a period that is required to pass
4 with respect to the employee before the employee is eligible to be
5 covered for benefits under the terms of the contract.

6 (y) “Registered domestic partner” means a person who has
7 established a domestic partnership as described in Section 297 of
8 the Family Code.

9 (z) “Family” means the policyholder and his or her dependents.

10 ~~SEC. 9.~~

11 *SEC. 10.* Section 10753.05 of the Insurance Code is amended
12 to read:

13 10753.05. (a) No group or individual policy or contract or
14 certificate of group insurance or statement of group coverage
15 providing benefits to employees of small employers as defined in
16 this chapter shall be issued or delivered by a carrier subject to the
17 jurisdiction of the commissioner regardless of the situs of the
18 contract or master policyholder or of the domicile of the carrier
19 nor, except as otherwise provided in Sections 10270.91 and
20 10270.92, shall a carrier provide coverage subject to this chapter
21 until a copy of the form of the policy, contract, certificate, or
22 statement of coverage is filed with and approved by the
23 commissioner in accordance with Sections 10290 and 10291, and
24 the carrier has complied with the requirements of Section 10753.17.

25 (b) (1) On and after October 1, 2013, each carrier shall fairly
26 and affirmatively offer, market, and sell all of the carrier’s health
27 benefit plans that are sold to, offered through, or sponsored by,
28 small employers or associations that include small employers for
29 plan years on or after January 1, 2014, to all small employers in
30 each geographic region in which the carrier makes coverage
31 available or provides benefits.

32 (2) A carrier that offers qualified health plans through the
33 Exchange shall be deemed to be in compliance with paragraph (1)
34 with respect to health benefit plans offered through the Exchange
35 in those geographic regions in which the carrier offers plans
36 through the Exchange.

37 (3) A carrier shall provide enrollment periods consistent with
38 PPACA and described in Section 155.725 of Title 45 of the Code
39 of Federal Regulations. Commencing January 1, 2014, a carrier
40 shall provide special enrollment periods consistent with the special

1 enrollment periods described in Section 10965.3, *to the extent*
2 *permitted by PPACA*, except for the triggering events identified
3 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
4 the Code of Federal Regulations with respect to health benefit
5 plans offered through the Exchange.

6 (4) Nothing in this section shall be construed to require an
7 association, or a trust established and maintained by an association
8 to receive a master insurance policy issued by an admitted insurer
9 and to administer the benefits thereof solely for association
10 members, to offer, market or sell a benefit plan design to those
11 who are not members of the association. However, if the
12 association markets, offers or sells a benefit plan design to those
13 who are not members of the association it is subject to the
14 requirements of this section. This shall apply to an association that
15 otherwise meets the requirements of paragraph (8) formed by
16 merger of two or more associations after January 1, 1992, if the
17 predecessor organizations had been in active existence on January
18 1, 1992, and for at least five years prior to that date and met the
19 requirements of paragraph (5).

20 (5) A carrier which (A) effective January 1, 1992, and at least
21 20 years prior to that date, markets, offers, or sells benefit plan
22 designs only to all members of one association and (B) does not
23 market, offer or sell any other individual, selected group, or group
24 policy or contract providing medical, hospital and surgical benefits
25 shall not be required to market, offer, or sell to those who are not
26 members of the association. However, if the carrier markets, offers
27 or sells any benefit plan design or any other individual, selected
28 group, or group policy or contract providing medical, hospital and
29 surgical benefits to those who are not members of the association
30 it is subject to the requirements of this section.

31 (6) Each carrier that sells health benefit plans to members of
32 one association pursuant to paragraph (5) shall submit an annual
33 statement to the commissioner which states that the carrier is selling
34 health benefit plans pursuant to paragraph (5) and which, for the
35 one association, lists all the information required by paragraph (7).

36 (7) Each carrier that sells health benefit plans to members of
37 any association shall submit an annual statement to the
38 commissioner which lists each association to which the carrier
39 sells health benefit plans, the industry or profession which is served
40 by the association, the association's membership criteria, a list of

1 officers, the state in which the association is organized, and the
2 site of its principal office.

3 (8) For purposes of paragraphs (4) and (6), an association is a
4 nonprofit organization comprised of a group of individuals or
5 employers who associate based solely on participation in a
6 specified profession or industry, accepting for membership any
7 individual or small employer meeting its membership criteria,
8 which do not condition membership directly or indirectly on the
9 health or claims history of any person, which uses membership
10 dues solely for and in consideration of the membership and
11 membership benefits, except that the amount of the dues shall not
12 depend on whether the member applies for or purchases insurance
13 offered by the association, which is organized and maintained in
14 good faith for purposes unrelated to insurance, which has been in
15 active existence on January 1, 1992, and at least five years prior
16 to that date, which has a constitution and bylaws, or other
17 analogous governing documents which provide for election of the
18 governing board of the association by its members, which has
19 contracted with one or more carriers to offer one or more health
20 benefit plans to all individual members and small employer
21 members in this state. Health coverage through an association that
22 is not related to employment shall be considered individual
23 coverage pursuant to Section 144.102(c) of Title 45 of the Code
24 of Federal Regulations.

25 (c) On and after October 1, 2013, each carrier shall make
26 available to each small employer all health benefit plans that the
27 carrier offers or sells to small employers or to associations that
28 include small employers for plan years on or after January 1, 2014.
29 Notwithstanding subdivision (d) of Section 10753, for purposes
30 of this subdivision, companies that are affiliated companies or that
31 are eligible to file a consolidated income tax return shall be treated
32 as one carrier.

33 (d) Each carrier shall do all of the following:

34 (1) Prepare a brochure that summarizes all of its health benefit
35 plans and make this summary available to small employers, agents,
36 and brokers upon request. The summary shall include for each
37 plan information on benefits provided, a generic description of the
38 manner in which services are provided, such as how access to
39 providers is limited, benefit limitations, required copayments and
40 deductibles, an explanation of how creditable coverage is calculated

1 if a waiting period is imposed, and a telephone number that can
2 be called for more detailed benefit information. Carriers are
3 required to keep the information contained in the brochure accurate
4 and up to date, and, upon updating the brochure, send copies to
5 agents and brokers representing the carrier. Any entity that provides
6 administrative services only with regard to a health benefit plan
7 written or issued by another carrier shall not be required to prepare
8 a summary brochure which includes that benefit plan.

9 (2) For each health benefit plan, prepare a more detailed
10 evidence of coverage and make it available to small employers,
11 agents and brokers upon request. The evidence of coverage shall
12 contain all information that a prudent buyer would need to be aware
13 of in making selections of benefit plan designs. An entity that
14 provides administrative services only with regard to a health benefit
15 plan written or issued by another carrier shall not be required to
16 prepare an evidence of coverage for that health benefit plan.

17 (3) Provide copies of the current summary brochure to all agents
18 or brokers who represent the carrier and, upon updating the
19 brochure, send copies of the updated brochure to agents and brokers
20 representing the carrier for the purpose of selling health benefit
21 plans.

22 (4) Notwithstanding subdivision (c) of Section 10753, for
23 purposes of this subdivision, companies that are affiliated
24 companies or that are eligible to file a consolidated income tax
25 return shall be treated as one carrier.

26 (e) Every agent or broker representing one or more carriers for
27 the purpose of selling health benefit plans to small employers shall
28 do all of the following:

29 (1) When providing information on a health benefit plan to a
30 small employer but making no specific recommendations on
31 particular benefit plan designs:

32 (A) Advise the small employer of the carrier's obligation to sell
33 to any small employer any of the health benefit plans it offers to
34 small employers, consistent with PPACA, and provide them, upon
35 request, with the actual rates that would be charged to that
36 employer for a given health benefit plan.

37 (B) Notify the small employer that the agent or broker will
38 procure rate and benefit information for the small employer on
39 any health benefit plan offered by a carrier for whom the agent or
40 broker sells health benefit plans.

1 (C) Notify the small employer that, upon request, the agent or
2 broker will provide the small employer with the summary brochure
3 required in paragraph (1) of subdivision (d) for any benefit plan
4 design offered by a carrier whom the agent or broker represents.

5 (D) Notify the small employer of the availability of coverage
6 and the availability of tax credits for certain employers consistent
7 with PPACA and state law, including any rules, regulations, or
8 guidance issued in connection therewith.

9 (2) When recommending a particular benefit plan design or
10 designs, advise the small employer that, upon request, the agent
11 will provide the small employer with the brochure required by
12 paragraph (1) of subdivision (d) containing the benefit plan design
13 or designs being recommended by the agent or broker.

14 (3) Prior to filing an application for a small employer for a
15 particular health benefit plan:

16 (A) For each of the health benefit plans offered by the carrier
17 whose health benefit plan the agent or broker is presenting, provide
18 the small employer with the benefit summary required in paragraph
19 (1) of subdivision (d) and the premium for that particular employer.

20 (B) Notify the small employer that, upon request, the agent or
21 broker will provide the small employer with an evidence of
22 coverage brochure for each health benefit plan the carrier offers.

23 (C) Obtain a signed statement from the small employer
24 acknowledging that the small employer has received the disclosures
25 required by this paragraph and Section 10753.16.

26 (f) No carrier, agent, or broker shall induce or otherwise
27 encourage a small employer to separate or otherwise exclude an
28 eligible employee from a health benefit plan which, in the case of
29 an eligible employee meeting the definition in paragraph (1) of
30 subdivision (f) of Section 10753, is provided in connection with
31 the employee's employment or which, in the case of an eligible
32 employee as defined in paragraph (2) of subdivision (f) of Section
33 10753, is provided in connection with a guaranteed association.

34 (g) No carrier shall reject an application from a small employer
35 for a health benefit plan provided:

36 (1) The small employer as defined by subparagraph (A) of
37 paragraph (1) of subdivision (q) of Section 10753 offers health
38 benefits to 100 percent of its eligible employees as defined in
39 paragraph (1) of subdivision (f) of Section 10753. Employees who

1 waive coverage on the grounds that they have other group coverage
2 shall not be counted as eligible employees.

3 (2) The small employer agrees to make the required premium
4 payments.

5 (h) No carrier or agent or broker shall, directly or indirectly,
6 engage in the following activities:

7 (1) Encourage or direct small employers to refrain from filing
8 an application for coverage with a carrier because of the health
9 status, claims experience, industry, occupation, or geographic
10 location within the carrier's approved service area of the small
11 employer or the small employer's employees.

12 (2) Encourage or direct small employers to seek coverage from
13 another carrier because of the health status, claims experience,
14 industry, occupation, or geographic location within the carrier's
15 approved service area of the small employer or the small
16 employer's employees.

17 (3) Employ marketing practices or benefit designs that will have
18 the effect of discouraging the enrollment of individuals with
19 significant health needs or discriminate based on the individual's
20 race, color, national origin, present or predicted disability, age,
21 sex, gender identity, sexual orientation, expected length of life,
22 degree of medical dependency, quality of life, or other health
23 conditions.

24 This subdivision shall be enforced in the same manner as Section
25 790.03, including through Sections 790.035 and 790.05.

26 (i) No carrier shall, directly or indirectly, enter into any contract,
27 agreement, or arrangement with an agent or broker that provides
28 for or results in the compensation paid to an agent or broker for a
29 health benefit plan to be varied because of the health status, claims
30 experience, industry, occupation, or geographic location of the
31 small employer or the small employer's employees. This
32 subdivision shall not apply with respect to a compensation
33 arrangement that provides compensation to an agent or broker on
34 the basis of percentage of premium, provided that the percentage
35 shall not vary because of the health status, claims experience,
36 industry, occupation, or geographic area of the small employer.

37 (j) (1) A health benefit plan offered to a small employer, as
38 defined in Section 1304(b) of PPACA and in Section 10753, shall
39 not establish rules for eligibility, including continued eligibility,
40 of an individual, or dependent of an individual, to enroll under the

1 terms of the plan based on any of the following health status-related
2 factors:

- 3 (A) Health status.
- 4 (B) Medical condition, including physical and mental illnesses.
- 5 (C) Claims experience.
- 6 (D) Receipt of health care.
- 7 (E) Medical history.
- 8 (F) Genetic information.
- 9 (G) Evidence of insurability, including conditions arising out
10 of acts of domestic violence.
- 11 (H) Disability.
- 12 (I) Any other health status-related factor as determined by any
13 federal regulations, rules, or guidance issued pursuant to Section
14 2705 of the federal Public Health Service Act.

15 (2) Notwithstanding Section 10291.5, a carrier shall not require
16 an eligible employee or dependent to fill out a health assessment
17 or medical questionnaire prior to enrollment under a health benefit
18 plan. A carrier shall not acquire or request information that relates
19 to a health status-related factor from the applicant or his or her
20 dependent or any other source prior to enrollment of the individual.

21 (k) (1) A carrier shall consider as a single risk pool for rating
22 purposes in the small employer market the claims experience of
23 all insureds in all nongrandfathered small employer health benefit
24 plans offered by the carrier in this state, whether offered as health
25 care service plan contracts or health insurance policies, including
26 those insureds and enrollees who enroll in coverage through the
27 Exchange and insureds and enrollees covered by the carrier outside
28 of the Exchange.

29 (2) Each calendar year, a carrier shall establish an index rate
30 for the small employer market in the state based on the total
31 combined claims costs for providing essential health benefits, as
32 defined pursuant to Section 1302 of PPACA and Section 10112.27,
33 within the single risk pool required under paragraph (1). The index
34 rate shall be adjusted on a marketwide basis based on the total
35 expected marketwide payments and charges under the risk
36 adjustment and reinsurance programs established for the state
37 pursuant to Sections 1343 and 1341 of PPACA. The premium rate
38 for all of the carrier's nongrandfathered health benefit plans shall
39 use the applicable index rate, as adjusted for total expected
40 marketwide payments and charges under the risk adjustment and

1 reinsurance programs established for the state pursuant to Sections
2 1343 and 1341 of PPACA, subject only to the adjustments
3 permitted under paragraph (3).

4 (3) A carrier may vary premium rates for a particular
5 nongrandfathered health benefit plan from its index rate based
6 only on the following actuarially justified plan-specific factors:

7 (A) The actuarial value and cost-sharing design of the health
8 benefit plan.

9 (B) The health benefit plan's provider network, delivery system
10 characteristics, and utilization management practices.

11 (C) The benefits provided under the health benefit plan that are
12 in addition to the essential health benefits, as defined pursuant to
13 Section 1302 of PPACA. These additional benefits shall be pooled
14 with similar benefits within the single risk pool required under
15 paragraph (1) and the claims experience from those benefits shall
16 be utilized to determine rate variations for health benefit plans that
17 offer those benefits in addition to essential health benefits.

18 (D) Administrative costs, excluding any user fees required by
19 the Exchange.

20 (E) With respect to catastrophic plans, as described in subsection
21 (e) of Section 1302 of PPACA, the expected impact of the specific
22 eligibility categories for those plans.

23 (l) If a carrier enters into a contract, agreement, or other
24 arrangement with a third-party administrator or other entity to
25 provide administrative, marketing, or other services related to the
26 offering of health benefit plans to small employers in this state,
27 the third-party administrator shall be subject to this chapter.

28 (m) (1) Except as provided in paragraph (2), this section shall
29 become inoperative if Section 2702 of the federal Public Health
30 Service Act (42 U.S.C. Sec. ~~300gg-4~~, *300gg-1*), as added by
31 Section 1201 of PPACA, is repealed, in which case, 12 months
32 after the repeal, carriers subject to this section shall instead be
33 governed by Section 10705 to the extent permitted by federal law,
34 and all references in this chapter to this section shall instead refer
35 to Section 10705, except for purposes of paragraph (2).

36 (2) Paragraph (3) of subdivision (b) of this section shall remain
37 operative as it relates to health benefit plans offered through the
38 Exchange.

1 ~~SEC. 10.~~

2 ~~SEC. 11.~~ Section 10753.06.5 of the Insurance Code is amended
3 to read:

4 10753.06.5. (a) With respect to *small employer* health benefit
5 plans offered outside the Exchange, after a small employer submits
6 a completed application, the carrier shall, within 30 days, notify
7 the employer of the employer's actual rates in accordance with
8 Section 10753.14. The employer shall have 30 days in which to
9 exercise the right to buy coverage at the quoted rates.

10 (b) Except as required under subdivision (c), when a small
11 employer submits a premium payment, based on the quoted rates,
12 and that payment is delivered or postmarked, whichever occurs
13 earlier, within the first 15 days of a month, coverage shall become
14 effective no later than the first day of the following month. When
15 that payment is neither delivered nor postmarked until after the
16 15th day of a month, coverage shall become effective no later than
17 the first day of the second month following delivery or postmark
18 of the payment.

19 (c) (1) With respect to a small employer health benefit plan
20 offered through the Exchange, a carrier shall apply coverage
21 effective dates consistent with those required under Section
22 155.720 of Title 45 of the Code of Federal Regulations and
23 paragraph (2) of subdivision (e) of Section 10965.3.

24 (2) With respect to a small employer health benefit plan offered
25 outside the Exchange for which an individual applies during a
26 special enrollment period described in paragraph (3) of subdivision
27 (b) of Section 10753.05, the following provisions shall apply:

28 (A) Coverage under the plan shall become effective no later
29 than the first day of the first calendar month beginning after the
30 date the carrier receives the request for special enrollment.

31 (B) Notwithstanding subparagraph (A), in the case of a birth,
32 adoption, or placement for adoption, coverage under the plan shall
33 become effective on the date of birth, adoption, or placement for
34 adoption.

35 (d) During the first 30 days of coverage, the small employer
36 shall have the option of changing coverage to a different health
37 benefit plan offered by the same carrier. If a small employer
38 notifies the carrier of the change within the first 15 days of a month,
39 coverage under the new health benefit plan shall become effective
40 no later than the first day of the following month. If a small

1 employer notifies the carrier of the change after the 15th day of a
 2 month, coverage under the new health benefit plan shall become
 3 effective no later than the first day of the second month following
 4 notification.

5 (e) All eligible employees and dependents listed on ~~the~~ a small
 6 employer's completed application shall be covered on the effective
 7 date of the health benefit plan.

8 ~~SEC. 11.~~

9 *SEC. 12.* Section 10753.11 of the Insurance Code is amended
 10 to read:

11 10753.11. (a) To the extent permitted by PPACA, ~~no~~ a carrier
 12 shall *not* be required by the provisions of this chapter to do ~~either~~
 13 *any* of the following:

14 (1) ~~To offer~~ *Offer* coverage to, or accept applications from, a
 15 small employer where the small employer is seeking coverage for
 16 eligible employees and dependents who do not live, work, or reside
 17 in a carrier's service areas.

18 (2) (A) ~~To offer~~ *Offer* coverage to, or accept applications from,
 19 a small employer for a benefits plan design within an area if the
 20 commissioner has found all of the following:

21 (i) The carrier will not have the capacity within the area in its
 22 network of providers to deliver service adequately to the eligible
 23 employees and dependents of that employee because of its
 24 obligations to existing group contractholders and enrollees.

25 (ii) The carrier is applying this paragraph uniformly to all
 26 employers without regard to the claims experience of those
 27 employers, and their employees and dependents, or any health
 28 status-related factor relating to those employees and dependents.

29 (iii) The action is not unreasonable or clearly inconsistent with
 30 the intent of this chapter.

31 (B) A carrier that cannot offer coverage to small employers in
 32 a specific service area because it is lacking sufficient capacity as
 33 described in this paragraph may not offer coverage in the applicable
 34 area to new employer groups until the later of the following dates:

35 (i) The 181st day after the date that coverage is denied pursuant
 36 to this paragraph.

37 (ii) The date the carrier notifies the commissioner that it has
 38 regained capacity to deliver services to small employers, and
 39 certifies to the commissioner that from the date of the notice it will
 40 enroll all small groups requesting coverage from the carrier until

1 the carrier has met the requirements of subdivision (g) of Section
2 10753.05.

3 (C) Subparagraph (B) shall not limit the carrier's ability to renew
4 coverage already in force or relieve the carrier of the responsibility
5 to renew that coverage as described in Sections 10273.4 and
6 10753.13.

7 (D) Coverage offered within a service area after the period
8 specified in subparagraph (B) shall be subject to the requirements
9 of this section.

10 ~~SEC. 12.~~

11 *SEC. 13.* Section 10753.12 of the Insurance Code is amended
12 to read:

13 10753.12. (a) A carrier shall not be required to offer coverage
14 or accept applications for benefit plan designs pursuant to this
15 chapter where the carrier demonstrates to the satisfaction of the
16 commissioner both of the following:

17 (1) The acceptance of an application or applications would place
18 the carrier in a financially impaired condition.

19 (2) The carrier is applying this subdivision uniformly to all
20 employers without regard to the claims experience of those
21 employers and their employees and dependents or any health
22 status-related factor relating to those employees and dependents.

23 (b) The commissioner's determination under subdivision (a)
24 shall follow an evaluation that includes a certification by the
25 commissioner that the acceptance of an application or applications
26 would place the carrier in a financially impaired condition.

27 (c) A carrier that has not offered coverage or accepted
28 applications pursuant to this chapter shall not offer coverage or
29 accept applications for any individual or group health benefit plan
30 until the later of the following dates:

31 (1) The 181st day after the date that coverage is denied pursuant
32 to this section.

33 (2) The date on which the carrier ceases to be financially
34 impaired, as determined by the commissioner.

35 (d) Subdivision (c) shall not limit the carrier's ability to renew
36 coverage already in force or relieve the carrier of the responsibility
37 to renew that coverage as described in Sections 10273.4, 10273.6,
38 and 10753.13.

1 (e) Coverage offered within a service area after the period
2 specified in subdivision (c) shall be subject to the requirements of
3 this section.

4 ~~SEC. 13.~~

5 *SEC. 14.* Section 10753.14 of the Insurance Code is amended
6 to read:

7 10753.14. (a) The premium rate for a *small employer* health
8 benefit plan issued, amended, or renewed on or after January 1,
9 2014, shall vary with respect to the particular coverage involved
10 only by the following:

11 (1) Age, pursuant to the age bands established by the United
12 States Secretary of Health and Human Services and the age rating
13 curve established by the Centers for Medicare and Medicaid
14 Services pursuant to Section 2701(a)(3) of the federal Public Health
15 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
16 be determined using the individual's age as of the date of the plan
17 issuance or renewal, as applicable, and shall not vary by more than
18 three to one for like individuals of different age who are 21 years
19 of age or older as described in federal regulations adopted pursuant
20 to Section 2701(a)(3) of the federal Public Health Service Act (42
21 U.S.C. Sec. 300gg(a)(3)).

22 (2) (A) Geographic region. The geographic regions for purposes
23 of rating shall be the following:

24 (i) Region 1 shall consist of the Counties of Alpine, Amador,
25 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
26 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
27 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

28 (ii) Region 2 shall consist of the Counties of Marin, Napa,
29 Solano, and Sonoma.

30 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
31 Sacramento, and Yolo.

32 (iv) Region 4 shall consist of the City and County of San
33 Francisco.

34 (v) Region 5 shall consist of the County of Contra Costa.

35 (vi) Region 6 shall consist of the County of Alameda.

36 (vii) Region 7 shall consist of the County of Santa Clara.

37 (viii) Region 8 shall consist of the County of San Mateo.

38 (ix) Region 9 shall consist of the Counties of Monterey, San
39 Benito, and Santa Cruz.

- 1 (x) Region 10 shall consist of the Counties of Mariposa, Merced,
2 San Joaquin, Stanislaus, and Tulare.
- 3 (xi) Region 11 shall consist of the Counties of Fresno, Kings,
4 and Madera.
- 5 (xii) Region 12 shall consist of the Counties of San Luis Obispo,
6 Santa Barbara, and Ventura.
- 7 (xiii) Region 13 shall consist of the Counties of Imperial, Inyo,
8 and Mono.
- 9 (xiv) Region 14 shall consist of the County of Kern.
- 10 (xv) Region 15 shall consist of the ZIP Codes in the County of
11 Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,
12 and 935.
- 13 (xvi) Region 16 shall consist of the ZIP Codes in the County of
14 Los Angeles other than those identified in clause (xv).
- 15 (xvii) Region 17 shall consist of the Counties of Riverside and
16 San Bernardino.
- 17 (xviii) Region 18 shall consist of the County of Orange.
- 18 (xix) Region 19 shall consist of the County of San Diego.
- 19 (B) ~~(i)~~—No later than June 1, 2017, the department, in
20 collaboration with the Exchange and the Department of Managed
21 Health Care, shall review the geographic rating regions specified
22 in this paragraph and the impacts of those regions on the health
23 care coverage market in California, and ~~make~~ *submit* a report to
24 the appropriate policy committees of the Legislature. *The*
25 *requirement for submitting a report imposed under this*
26 *subparagraph is inoperative June 1, 2021, pursuant to Section*
27 *10231.5 of the Government Code.*
- 28 ~~(ii) The requirement for submitting a report imposed under this~~
29 ~~subparagraph is inoperative June 1, 2021, pursuant to Section~~
30 ~~10231.5 of the Government Code.~~
- 31 (3) Whether the health benefit plan covers an individual or
32 family, as described in PPACA.
- 33 (b) The rate for a health benefit plan subject to this section shall
34 not vary by any factor not described in this section.
- 35 (c) The total premium charged to a small employer pursuant to
36 this section shall be determined by summing the premiums of
37 covered employees and dependents in accordance with Section
38 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

1 (d) The rating period for rates subject to this section shall be no
 2 less than 12 months from the date of issuance or renewal of the
 3 health benefit plan.

4 (e) ~~This section shall become inoperative if~~ *If* Section 2701 of
 5 the federal Public Health ~~Services Service~~ Act (42 U.S.C. Sec.
 6 300gg), as added by Section 1201 of PPACA, is repealed, ~~in which~~
 7 ~~case, this section shall become inoperative~~ 12 months after the
 8 ~~repeat, repeal date, in which case~~ rates for health benefit plans
 9 subject to this section shall instead be subject to Section 10714,
 10 to the extent permitted by federal law, and all references to this
 11 section shall be deemed to be references to Section 10714.

12 ~~SEC. 14.~~

13 *SEC. 15.* Section 10902.4 of the Insurance Code is repealed.

14 ~~SEC. 15.~~

15 *SEC. 16.* The heading of Chapter 9.7 (commencing with Section
 16 10950) of Part 2 of Division 2 of the Insurance Code is amended
 17 to read:

18
 19 CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

20

21 ~~SEC. 16.~~

22 *SEC. 17.* Section 10954 of the Insurance Code is amended to
 23 read:

24 10954. (a) A carrier may use the following characteristics of
 25 an eligible child for purposes of establishing the rate of the health
 26 benefit plan for that child, where consistent with federal regulations
 27 under PPACA: age, geographic region, and family composition,
 28 plus the health benefit plan selected by the child or the responsible
 29 party for a child.

30 (b) From the effective date of this chapter to December 31,
 31 2013, inclusive, rates for a child applying for coverage shall be
 32 subject to the following limitations:

33 (1) During any open enrollment period or for late enrollees, the
 34 rate for any child due to health status shall not be more than two
 35 times the standard risk rate for a child.

36 (2) The rate for a child shall be subject to a 20-percent surcharge
 37 above the highest allowable rate on a child applying for coverage
 38 who is not a late enrollee and who failed to maintain coverage with
 39 any carrier or health care service plan for the 90-day period prior
 40 to the date of the child’s application. The surcharge shall apply

1 for the 12-month period following the effective date of the child's
2 coverage.

3 (3) If expressly permitted under PPACA and any rules,
4 regulations, or guidance issued pursuant to that act, a carrier may
5 rate a child based on health status during any period other than an
6 open enrollment period if the child is not a late enrollee.

7 (4) If expressly permitted under PPACA and any rules,
8 regulations, or guidance issued pursuant to that act, a carrier may
9 condition an offer or acceptance of coverage on any preexisting
10 condition or other health status-related factor for a period other
11 than an open enrollment period and for a child who is not a late
12 enrollee.

13 (c) For any individual health benefit plan issued, sold, or
14 renewed prior to December 31, 2013, the carrier shall provide to
15 a child or responsible party for a child a notice that states the
16 following:

17
18 "Please consider your options carefully before failing to maintain
19 or renewing coverage for a child for whom you are responsible.
20 If you attempt to obtain new individual coverage for that child,
21 the premium for the same coverage may be higher than the
22 premium you pay now."
23

24 (d) A child who applied for coverage between September 23,
25 2010, and the end of the initial enrollment period shall be deemed
26 to have maintained coverage during that period.

27 (e) Effective January 1, 2014, except for individual
28 grandfathered health plan coverage, the rate for any child shall be
29 identical to the standard risk rate.

30 (f) Carriers shall not require documentation from applicants
31 relating to their coverage history.

32 (g) (1) On and after the operative date of the act adding this
33 subdivision, and until January 1, 2014, a carrier shall provide the
34 model notice, as provided in paragraph (3), to all applicants for
35 coverage under this chapter and to all insureds, or the responsible
36 party for an insured, renewing coverage under this chapter that
37 contains the following information:

38 (A) Information about the open enrollment period provided
39 under Section 10965.3.

1 (B) An explanation that obtaining coverage during the open
 2 enrollment period described in Section 10965.3 will not affect the
 3 effective dates of coverage for coverage purchased pursuant to
 4 this chapter unless the applicant cancels that coverage.

5 (C) An explanation that coverage purchased pursuant to this
 6 chapter shall be effective as required under subdivision (d) of
 7 Section 10951 and that such coverage shall not prevent an applicant
 8 from obtaining new coverage during the open enrollment period
 9 described in Section 10965.3.

10 (D) Information about the Medi-Cal ~~program and~~ *program*,
 11 *information about* the Healthy Families Program *if the Healthy*
 12 *Families Program is accepting enrollment*, and *information* about
 13 subsidies available through the California Health Benefit Exchange.

14 (2) The notice described in paragraph (1) shall be in plain
 15 language and 14-point type.

16 (3) The department shall adopt a uniform model notice to be
 17 used by carriers in order to comply with this subdivision, and shall
 18 consult with the Department of Managed Health Care in adopting
 19 that uniform model notice. Use of the model notice shall not require
 20 prior approval of the department. *The adoption of the* model notice
 21 ~~adopted~~ by the department for purposes of this section shall not
 22 be subject to the Administrative Procedure Act (Chapter 3.5
 23 (commencing with Section 11340) of Part 1 of Division 3 of Title
 24 2 of the Government Code).

25 ~~SEC. 17.~~

26 *SEC. 18.* Section 10960.5 is added to the Insurance Code, to
 27 read:

28 10960.5. (a) This chapter shall become inoperative on January
 29 1, 2014, or the 91st calendar day following the adjournment of the
 30 2013–14 First Extraordinary Session, whichever date is later.

31 (b) If Section 5000A of the Internal Revenue Code, as added
 32 by Section 1501 of PPACA, is repealed or amended to no longer
 33 apply to the individual market, as defined in Section 2791 of the
 34 federal Public Health ~~Services~~ *Service* Act (42 U.S.C. Sec.
 35 300gg-4), ~~this section~~ *chapter* shall become operative 12 months
 36 after the date of that repeal or amendment.

37 ~~SEC. 18.~~

38 *SEC. 19.* Chapter 9.9 (commencing with Section 10965) is
 39 added to Part 2 of Division 2 of the Insurance Code, to read:

1 CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

2
3 10965. For purposes of this chapter, the following definitions
4 shall apply:

5 (a) “Child” means a child described in Section 22775 of the
6 Government Code and subdivisions (n) to (p), inclusive, of Section
7 599.500 of Title 2 of the California Code of Regulations.

8 (b) “Dependent” means the spouse or registered domestic
9 partner, or child, of an individual, subject to applicable terms of
10 the health benefit plan.

11 (c) “Exchange” means the California Health Benefit Exchange
12 created by Section 100500 of the Government Code.

13 (d) “Family” means the policyholder and dependent or
14 dependents.

15 (e) “Grandfathered health plan” has the same meaning as that
16 term is defined in Section 1251 of PPACA.

17 (f) “Health benefit plan” means any individual or group policy
18 of health insurance, as defined in Section 106. The term does not
19 include a health insurance policy that provides excepted benefits,
20 as described in Sections 2722 and 2791 of the federal Public Health
21 Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91),
22 subject to Section 10965.01 a health insurance policy provided in
23 the Medi-Cal program (Chapter 7 (commencing with Section
24 14000) of Part 3 of Division 9 of the Welfare and Institutions
25 Code), the Healthy Families Program (Part 6.2 (commencing with
26 Section 12693) of Division 2), the Access for Infants and Mothers
27 Program (Part 6.3 (commencing with Section 12695) of Division
28 2), or the program under Part 6.4 (commencing with Section
29 12699.50) of Division 2, *or Medicare supplement coverage*, to
30 the extent consistent with PPACA or a specified disease or hospital
31 indemnity policy, subject to Section 10965.01.

32 (g) “Policy year” ~~has the meaning set forth in Section 144.103~~
33 ~~of Title 45 of the Code of Federal Regulations.~~ *means the period*
34 *from January 1 to December 31, inclusive.*

35 (h) “PPACA” means the federal Patient Protection and
36 Affordable Care Act (Public Law 111-148), as amended by the
37 federal Health Care and Education Reconciliation Act of 2010
38 (Public Law 111-152), and any rules, regulations, or guidance
39 issued pursuant to that law.

1 (i) “Preexisting condition provision” means a policy provision
2 that excludes coverage for charges or expenses incurred during a
3 specified period following the insured’s effective date of coverage,
4 as to a condition for which medical advice, diagnosis, care, or
5 treatment was recommended or received during a specified period
6 immediately preceding the effective date of coverage.

7 (j) “Rating period” means the calendar year for which premium
8 rates are in effect pursuant to subdivision (d) of Section 10965.9.

9 (k) “Registered domestic partner” means a person who has
10 established a domestic partnership as described in Section 297 of
11 the Family Code.

12 10965.01. (a) For purposes of this chapter, “health benefit
13 plan” does not include policies or certificates of specified disease
14 or hospital confinement indemnity provided that the carrier offering
15 those policies or certificates complies with the following:

16 (1) The carrier files, on or before March 1 of each year, a
17 certification with the commissioner that contains the statement
18 and information described in paragraph (2).

19 (2) The certification required in paragraph (1) shall contain the
20 following:

21 (A) A statement from the carrier certifying that policies or
22 certificates described in this section (i) are being offered and
23 marketed as supplemental health insurance and not as a substitute
24 for coverage that provides essential health benefits as defined by
25 the state pursuant to Section 1302 of PPACA, and (ii) the disclosure
26 forms as described in Section 10603 contains the following
27 statement prominently on the first page:

28
29 “This is a supplement to health insurance. It is not a substitute
30 for essential health benefits or minimum essential coverage as
31 defined in federal law.”

32
33 (B) A summary description of each policy or certificate
34 described in this section, including the average annual premium
35 rates, or range of premium rates in cases where premiums vary by
36 age, gender, or other factors, charged for the policies and
37 certificates issued or delivered in this state.

38 (3) In the case of a policy or certificate that is described in this
39 section and that is offered in this state on or after January 1, 2014,
40 the carrier files with the commissioner the information and

1 statement required in paragraph (2) at least 30 days prior to the
2 date such a policy or certificate is issued or delivered in this state.

3 (4) The carrier issuing a policy or certificate of specified disease
4 or a policy or certificate of hospital confinement indemnity requires
5 that the person to be insured is covered by an individual or group
6 policy or contract that arranges or provides medical, hospital, and
7 surgical coverage not designed to supplement other private or
8 governmental plans.

9 (b) As used in this section, “policies or certificates of specified
10 disease” and “policies or certificates of hospital confinement
11 indemnity” mean policies or certificates of insurance sold to an
12 insured to supplement other health insurance coverage as specified
13 in this section.

14 ~~10965.1. Every health insurer offering individual health benefit
15 plans shall, in addition to complying with the provisions of this
16 part and rules adopted thereunder, comply with the provisions of
17 this chapter.~~

18 *10965.1. Except as provided in Section 10965.15, the provisions
19 of this chapter shall only apply with respect to nongrandfathered
20 individual health benefit plans offered by a health insurer, and
21 shall apply in addition to other provisions of this chapter and the
22 rules adopted thereunder.*

23 10965.3. (a) (1) On and after October 1, 2013, a health insurer
24 shall fairly and affirmatively offer, market, and sell all of the
25 insurer’s health benefit plans that are sold in the individual market
26 for policy years on or after January 1, 2014, to all individuals and
27 dependents in each service area in which the insurer provides or
28 arranges for the provision of health care services. A health insurer
29 shall limit enrollment in individual health benefit plans to open
30 enrollment periods and special enrollment periods as provided in
31 subdivisions (c) and (d).

32 (2) A health insurer shall allow the policyholder of an individual
33 health benefit plan to add a dependent to the policyholder’s health
34 benefit plan at the option of the policyholder, consistent with the
35 open enrollment, annual enrollment, and special enrollment period
36 requirements in this section.

37 (b) An individual health benefit plan issued, amended, or
38 renewed on or after January 1, 2014, shall not impose any
39 preexisting condition provision upon any individual.

1 (c) (1) A health insurer shall provide an initial open enrollment
2 period from October 1, 2013, to March 31, 2014, inclusive, and
3 annual enrollment periods for plan years on or after January 1,
4 2015, from October 15 to December 7, inclusive, of the preceding
5 calendar year.

6 (2) ~~For Pursuant to Section 147.104(b)(2) of Title 45 of the~~
7 ~~Code of Federal Regulations, for~~ individuals enrolled in
8 noncalendar-year individual health plan contracts, a plan shall
9 provide a limited open enrollment period beginning on the date
10 that is 30 calendar days prior to the date the policy year ends in
11 2014 pursuant to Section 147.104(b)(2) of Title 45 of the Code of
12 Federal Regulations. 2014.

13 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
14 a health insurer shall allow an individual to enroll in or change
15 individual health benefit plans as a result of the following triggering
16 events:

17 (A) He or she or his or her dependent loses minimum essential
18 coverage. For purposes of this paragraph, both of the following
19 definitions shall apply:

20 (i) “Minimum essential coverage” has the same meaning as that
21 term is defined in subsection (f) of Section 5000A of the Internal
22 Revenue Code (26 U.S.C. Sec. 5000A).

23 (ii) “Loss of minimum essential coverage” includes, but is not
24 limited to, loss of that coverage due to the circumstances described
25 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
26 Code of Federal Regulations and the circumstances described in
27 Section 1163 of Title 29 of the United States Code. “Loss of
28 minimum essential coverage” also includes loss of that coverage
29 for a reason that is not due to the fault of the individual.

30 (iii) “Loss of minimum essential coverage” does not include
31 loss of that coverage due to the individual’s failure to pay
32 premiums on a timely basis or situations allowing for a rescission,
33 subject to clause (ii) and Sections 10119.2 and 10384.17.

34 (B) He or she gains a dependent or becomes a dependent.

35 (C) He or she is mandated to be covered as a dependent pursuant
36 to a valid state or federal court order.

37 (D) He or she has been released from incarceration.

38 (E) His or her health coverage issuer substantially violated a
39 material provision of the health coverage contract.

1 (F) He or she gains access to new health benefit plans as a result
2 of a permanent move.

3 (G) He or she was receiving services from a contracting provider
4 under another health benefit plan, as defined in Section 10965 or
5 Section 1399.845 of the Health and Safety Code for one of the
6 conditions described in subdivision (a) of Section 10133.56 and
7 that provider is no longer participating in the health benefit plan.

8 (H) He or she demonstrates to the Exchange, with respect to
9 health benefit plans offered through the Exchange, or to the
10 department, with respect to health benefit plans offered outside
11 the Exchange, that he or she did not enroll in a health benefit plan
12 during the immediately preceding enrollment period available to
13 the individual because he or she was misinformed that he or she
14 was covered under minimum essential coverage.

15 (I) With respect to individual health benefit plans offered
16 through the Exchange, in addition to the triggering events listed
17 in this paragraph, any other events listed in Section 155.420(d) of
18 Title 45 of the Code of Federal Regulations.

19 (2) With respect to individual health benefit plans offered
20 outside the Exchange, an individual shall have 60 days from the
21 date of a triggering event identified in paragraph (1) to apply for
22 coverage from a health care service plan subject to this section.
23 With respect to individual health benefit plans offered through the
24 Exchange, an individual shall have 60 days from the date of a
25 triggering event identified in paragraph (1) to select a plan offered
26 through the Exchange, unless a longer period is provided in Part
27 155 (commencing with Section 155.10) of Subchapter B of Subtitle
28 A of Title 45 of the Code of Federal Regulations.

29 (e) With respect to individual health benefit plans offered
30 through the Exchange, the effective date of coverage required
31 pursuant to this section shall be consistent with the dates specified
32 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
33 ~~Regulations. Regulations, as applicable.~~ A dependent ~~that~~ who is
34 a registered domestic partner pursuant to Section 297 of the Family
35 Code shall have the same effective date of coverage as a spouse.

36 (f) With respect to an individual health benefit plan offered
37 outside the Exchange, the following provisions shall apply:

38 (1) After an individual submits a completed application form
39 for a plan, the insurer shall, within 30 days, notify the individual
40 of the individual's actual premium charges for that plan established

1 in accordance with Section 10965.9. The individual shall have 30
2 days in which to exercise the right to buy coverage at the quoted
3 premium charges.

4 (2) With respect to an individual health benefit plan for which
5 an individual applies during the initial open enrollment period
6 described in subdivision (c), when the policyholder submits a
7 premium payment, based on the quoted premium charges, and that
8 payment is delivered or postmarked, whichever occurs earlier, by
9 December 15, 2013, coverage under the individual health benefit
10 plan shall become effective no later than January 1, 2014. When
11 that payment is delivered or postmarked within the first 15 days
12 of any subsequent month, coverage shall become effective no later
13 than the first day of the following month. When that payment is
14 delivered or postmarked between December 16, 2013, and
15 December 31, 2013, inclusive, or after the 15th day of any
16 subsequent month, coverage shall become effective no later than
17 the first day of the second month following delivery or postmark
18 of the payment.

19 (3) With respect to an individual health benefit plan for which
20 an individual applies during the annual open enrollment period
21 described in subdivision (c), when the individual submits a
22 premium payment, based on the quoted premium charges, and that
23 payment is delivered or postmarked, whichever occurs later, by
24 December 15, coverage shall become effective as of the following
25 January 1. When that payment is delivered or postmarked within
26 the first 15 days of any subsequent month, coverage shall become
27 effective no later than the first day of the following month. When
28 that payment is delivered or postmarked between December 16
29 and December 31, inclusive, or after the 15th day of any subsequent
30 month, coverage shall become effective no later than the first day
31 of the second month following delivery or postmark of the
32 payment.

33 (4) With respect to an individual health benefit plan for which
34 an individual applies during a special enrollment period described
35 in subdivision (d), the following provisions shall apply:

36 (A) When the individual submits a premium payment, based
37 on the quoted premium charges, and that payment is delivered or
38 postmarked, whichever occurs earlier, within the first 15 days of
39 the month, coverage under the plan shall become effective no later
40 than the first day of the following month. When the premium

1 payment is neither delivered nor postmarked until after the 15th
2 day of the month, coverage shall become effective no later than
3 the first day of the second month following delivery or postmark
4 of the payment.

5 (B) Notwithstanding subparagraph (A), in the case of a birth,
6 adoption, or placement for adoption, the coverage shall be effective
7 on the date of birth, adoption, or placement for adoption.

8 (C) Notwithstanding subparagraph (A), in the case of marriage
9 or becoming a registered domestic partner or in the case where a
10 qualified individual loses minimum essential coverage, the
11 coverage effective date shall be the first day of the month following
12 the date the insurer receives the request for special enrollment.

13 (g) (1) A health insurer shall not establish rules for eligibility,
14 including continued eligibility, of any individual to enroll under
15 the terms of an individual health benefit plan based on any of the
16 following factors:

17 (A) Health status.

18 (B) Medical condition, including physical and mental illnesses.

19 (C) Claims experience.

20 (D) Receipt of health care.

21 (E) Medical history.

22 (F) Genetic information.

23 (G) Evidence of insurability, including conditions arising out
24 of acts of domestic violence.

25 (H) Disability.

26 (I) Any other health status-related factor as determined by any
27 federal regulations, rules, or guidance issued pursuant to Section
28 2705 of the federal Public Health Service Act.

29 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
30 insurer shall not require an individual applicant or his or her
31 dependent to fill out a health assessment or medical questionnaire
32 prior to enrollment under an individual health benefit plan. A health
33 insurer shall not acquire or request information that relates to a
34 health status-related factor from the applicant or his or her
35 dependent or any other source prior to enrollment of the individual.

36 (h) (1) A health insurer shall consider as a single risk pool for
37 rating purposes in the individual market the claims experience of
38 all insureds and enrollees in all nongrandfathered individual health
39 benefit plans offered by that insurer in this state, whether offered
40 as health care service plan contracts or individual health insurance

1 policies, including those insureds who enroll in individual coverage
2 through the Exchange and insureds who enroll in individual
3 coverage outside the Exchange. *Student health insurance coverage,*
4 *as such coverage is defined at Section 147.145(a) of Title 45 of*
5 *the Code of Federal Regulations, shall not be included in a health*
6 *insurer's single risk pool for individual coverage.*

7 (2) Each calendar year, a health insurer shall establish an index
8 rate for the individual market in the state based on the total
9 combined claims costs for providing essential health benefits, as
10 defined pursuant to Section 1302 of PPACA, within the single risk
11 pool required under paragraph (1). The index rate shall be adjusted
12 on a marketwide basis based on the total expected marketwide
13 payments and charges under the risk adjustment and reinsurance
14 programs established for the state pursuant to Sections 1343 and
15 1341 of PPACA. The premium rate for all of the health insurer's
16 health benefit plans in the individual market shall use the applicable
17 index rate, as adjusted for total expected marketwide payments
18 and charges under the risk adjustment and reinsurance programs
19 established for the state pursuant to Sections 1343 and 1341 of
20 PPACA, subject only to the adjustments permitted under paragraph
21 (3).

22 (3) A health insurer may vary premium rates for a particular
23 health benefit plan from its index rate based only on the following
24 actuarially justified plan-specific factors:

25 (A) The actuarial value and cost-sharing design of the health
26 benefit plan.

27 (B) The health benefit plan's provider network, delivery system
28 characteristics, and utilization management practices.

29 (C) The benefits provided under the health benefit plan that are
30 in addition to the essential health benefits, as defined pursuant to
31 Section 1302 of PPACA and Section 10112.27. These additional
32 benefits shall be pooled with similar benefits within the single risk
33 pool required under paragraph (1) and the claims experience from
34 those benefits shall be utilized to determine rate variations for
35 plans that offer those benefits in addition to essential health
36 benefits.

37 (D) With respect to catastrophic plans, as described in subsection
38 (e) of Section 1302 of ~~PPACA and Section 10112.3~~; *PPACA*, the
39 expected impact of the specific eligibility categories for those
40 plans.

1 (E) Administrative costs, excluding any user fees required by
2 the Exchange.

3 (i) This section shall only apply with respect to individual health
4 benefit plans for policy years on or after January 1, 2014.

5 (j) This section shall not apply to an individual health benefit
6 plan that is a grandfathered health plan.

7 (k) If Section 5000A of the Internal Revenue Code, as added
8 by Section 1501 of PPACA, is repealed or amended to no longer
9 apply to the individual market, as defined in Section 2791 of the
10 federal Public Health—~~Services~~ *Service* Act (42 U.S.C. Sec.
11 300gg-4), subdivisions (a), (b), and (g) shall become inoperative
12 12 months after the date of that repeal or amendment and individual
13 health care benefit plans shall thereafter be subject to Sections
14 10901.2, 10951, and 10953.

15 10965.5. (a) Commencing on October 1, 2013, ~~no~~ a health
16 insurer or agent or broker ~~shall~~, *shall not*, directly or indirectly,
17 engage in the following activities:

18 (1) Encourage or direct an individual to refrain from filing an
19 application for individual coverage with an insurer because of the
20 health status, claims experience, industry, occupation, or
21 geographic location, provided that the location is within the
22 insurer's approved service area, of the individual.

23 (2) Encourage or direct an individual to seek individual coverage
24 from another health care service plan or health insurer or the
25 *California Health Benefit* Exchange because of the health status,
26 claims experience, industry, occupation, or geographic location,
27 provided that the location is within the insurer's approved service
28 area, of the individual.

29 (3) Employ marketing practices or benefit designs that will have
30 the effect of discouraging the enrollment of individuals with
31 significant health needs or discriminate based on an individual's
32 race, color, national origin, present or predicted disability, age,
33 sex, gender identity, sexual orientation, expected length of life,
34 degree of medical dependency, quality of life, or other health
35 conditions.

36 (b) Commencing on October 1, 2013, a health insurer shall not,
37 directly or indirectly, enter into any contract, agreement, or
38 arrangement with a broker or agent that provides for or results in
39 the compensation paid to a broker or agent for the sale of an
40 individual health benefit plan to be varied because of the health

1 status, claims experience, industry, occupation, or geographic
 2 location of the individual. This subdivision does not apply to a
 3 compensation arrangement that provides compensation to a broker
 4 or agent on the basis of percentage of premium, provided that the
 5 percentage shall not vary because of the health status, claims
 6 experience, industry, occupation, or geographic area of the
 7 individual.

8 (c) This section shall only apply with respect to individual health
 9 benefit plans for policy years on or after January 1, 2014.

10 (d) This section shall be enforced in the same manner as Section
 11 790.03, including through Sections 790.05 and 790.035.

12 10965.7. (a) ~~At~~ *An* individual health benefit ~~plans~~ *plan* shall
 13 ~~conform to the requirements of Sections 10112.1, 10127.18,~~
 14 ~~10273.6, and 12682.1, and any other requirements imposed by this~~
 15 ~~code, and shall be renewable at the option of the insured except~~
 16 ~~as permitted to be canceled, rescinded, or not renewed pursuant~~
 17 ~~to Section 10273.6. 155.430(b) of Title 45 of the Code of Federal~~
 18 ~~Regulations.~~

19 (b) Any insurer that ceases to offer for sale new individual health
 20 benefit plans pursuant to Section 10273.6 shall continue to be
 21 governed by this chapter with respect to business conducted under
 22 this chapter.

23 10965.9. (a) With respect to individual health benefit plans
 24 issued, amended, or renewed on or after January 1, 2014, a health
 25 insurer may use only the following characteristics of an individual,
 26 and any dependent thereof, for purposes of establishing the rate
 27 of the individual health benefit plan covering the individual and
 28 the eligible dependents thereof, along with the health benefit plan
 29 selected by the individual:

30 (1) Age, pursuant to the age bands established by the United
 31 States Secretary of Health and Human Services and the age rating
 32 curve established by the federal Centers for Medicare and Medicaid
 33 Services pursuant to Section 2701(a)(3) of the federal Public Health
 34 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
 35 be determined using the individual's age as of the date of the plan
 36 issuance or renewal, as applicable, and shall not vary by more than
 37 three to one for like individuals of different ~~age~~ *ages* who are 21
 38 years of age or older as described in federal regulations adopted
 39 pursuant to Section 2701(a)(3) of the federal Public Health Service
 40 Act (42 U.S.C. Sec. 300gg(a)(3)).

- 1 (2) (A) Geographic region. The geographic regions for purposes
2 of rating shall be the following:
- 3 (i) Region 1 shall consist of the Counties of Alpine, Amador,
4 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
5 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
6 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.
 - 7 (ii) Region 2 shall consist of the Counties of Marin, Napa,
8 Solano, and Sonoma.
 - 9 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
10 Sacramento, and Yolo.
 - 11 (iv) Region 4 shall consist of the City and County of San
12 Francisco.
 - 13 (v) Region 5 shall consist of the County of Contra Costa.
 - 14 (vi) Region 6 shall consist of the County of Alameda.
 - 15 (vii) Region 7 shall consist of the County of Santa Clara.
 - 16 (viii) Region 8 shall consist of the County of San Mateo.
 - 17 (ix) Region 9 shall consist of the Counties of Monterey, San
18 Benito, and Santa Cruz.
 - 19 (x) Region 10 shall consist of the Counties of Mariposa, Merced,
20 San Joaquin, Stanislaus, and Tulare.
 - 21 (xi) Region 11 shall consist of the Counties of Fresno, Kings,
22 and Madera.
 - 23 (xii) Region 12 shall consist of the Counties of San Luis Obispo,
24 Santa Barbara, and Ventura.
 - 25 (xiii) Region 13 shall consist of the Counties of Imperial, Inyo,
26 and Mono.
 - 27 (xiv) Region 14 shall consist of the County of Kern.
 - 28 (xv) Region 15 shall consist of the ZIP Codes in the County of
29 Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,
30 and 935.
 - 31 (xvi) Region 16 shall consist of the ZIP Codes in the County of
32 Los Angeles other than those identified in clause (xv).
 - 33 (xvii) Region 17 shall consist of the Counties of Riverside and
34 San Bernardino.
 - 35 (xviii) Region 18 shall consist of the County of Orange.
 - 36 (xix) Region 19 shall consist of the County of San Diego.
- 37 (B) No later than June 1, 2017, the department, in collaboration
38 with the Exchange and the Department of Managed Health Care,
39 shall review the geographic rating regions specified in this
40 paragraph and the impacts of those regions on the health care

1 coverage market in California, and make a report to the appropriate
2 policy committees of the Legislature.

3 (3) Whether the plan covers an individual or family, as described
4 in PPACA.

5 (b) The rate for a health benefit plan subject to this section shall
6 not vary by any factor not described in this section.

7 (c) With respect to family coverage under an individual health
8 benefit plan, the rating variation permitted under paragraph (1) of
9 subdivision (a) shall be applied based on the portion of the
10 premium attributable to each family member covered under the
11 plan. The total premium for family coverage shall be determined
12 by summing the premiums for each individual family member. In
13 determining the total premium for family members, premiums for
14 no more than the three oldest family members who are under 21
15 years of age shall be taken into account.

16 (d) The rating period for rates subject to this section shall be
17 from January 1 to December 31, inclusive.

18 (e) This section shall not apply to an individual health benefit
19 plan that is a grandfathered health plan.

20 (f) The requirement for submitting a report imposed under
21 subparagraph (B) of paragraph (2) of subdivision (a) is inoperative
22 on June 1, 2021, pursuant to Section 10231.5 of the Government
23 Code.

24 (g) If Section 5000A of the Internal Revenue Code, as added
25 by Section 1501 of PPACA, is repealed or amended to no longer
26 apply to the individual market, as defined in Section 2791 of the
27 federal Public Health—Services Service Act (42 U.S.C. Sec.
28 300gg-4), this section shall become inoperative 12 months after
29 the date of that repeal or the amendment.

30 10965.11. (a) A health insurer shall not be required to offer
31 an individual health benefit plan or accept applications for the plan
32 pursuant to Section 10965.3 in the case of any of the following:

33 (1) To an individual who does not live or reside within the
34 insurer's approved service areas.

35 (2) (A) Within a specific service area or portion of a service
36 area, if the insurer reasonably anticipates and demonstrates to the
37 satisfaction of the commissioner both of the following:

38 (i) It will not have sufficient health care delivery resources to
39 ensure that health care services will be available and accessible to
40 the individual because of its obligations to existing insureds.

1 (ii) It is applying this subparagraph uniformly to all individuals
2 without regard to the claims experience of those individuals or any
3 health status-related factor relating to those individuals.

4 (B) A health insurer that cannot offer ~~a~~ *an individual* health
5 benefit plan to individuals because it is lacking in sufficient health
6 care delivery resources within a service area or a portion of a
7 service area pursuant to subparagraph (A) shall not offer ~~a~~ *an*
8 *individual* health benefit plan in that area until the later of the
9 following dates:

10 (i) The 181st day after the date coverage is denied pursuant to
11 this paragraph.

12 (ii) The date the insurer notifies the commissioner that it has
13 the ability to deliver services to individuals, and certifies to the
14 commissioner that from the date of the notice it will enroll all
15 individuals requesting coverage in that area from the insurer.

16 (C) Subparagraph (B) shall not limit the insurer's ability to
17 renew coverage already in force or relieve the insurer of the
18 responsibility to renew that coverage as described in Section
19 10273.6.

20 (D) Coverage offered within a service area after the period
21 specified in subparagraph (B) shall be subject to this section.

22 (b) (1) A health insurer may decline to offer an individual health
23 benefit plan to an individual if the insurer demonstrates to the
24 satisfaction of the commissioner both of the following:

25 (A) It does not have the financial reserves necessary to
26 underwrite additional coverage. In determining whether this
27 subparagraph has been satisfied, the commissioner shall consider,
28 but not be limited to, the insurer's compliance with the
29 requirements of this part and the rules adopted ~~under those~~
30 ~~provisions.~~ *thereunder.*

31 (B) It is applying this subdivision uniformly to all individuals
32 without regard to the claims experience of those individuals or any
33 health status-related factor relating to those individuals.

34 (2) A health insurer that denies coverage to an individual under
35 paragraph (1) shall not offer coverage before the later of the
36 following dates:

37 (A) The 181st day after the date coverage is denied pursuant to
38 this subdivision.

1 (B) The date the insurer demonstrates to the satisfaction of the
2 commissioner that the insurer has sufficient financial reserves
3 necessary to underwrite additional coverage.

4 (3) Paragraph (2) shall not limit the insurer's ability to renew
5 coverage already in force or relieve the insurer of the responsibility
6 to renew that coverage as described in Section 10273.6.

7 (C) Coverage offered within a service area after the period
8 specified in paragraph (2) shall be subject to this section.

9 (c) Nothing in this chapter shall be construed to limit the
10 commissioner's authority to develop and implement a plan of
11 rehabilitation for a health insurer whose financial viability or
12 organizational and administrative capacity has become impaired,
13 to the extent permitted by PPACA.

14 (d) *This section shall not apply to an individual health benefit*
15 *plan that is a grandfathered plan.*

16 10965.13. (a) A health insurer that receives an application for
17 an individual health benefit plan outside the Exchange during the
18 initial open enrollment period, an annual enrollment period, or a
19 special enrollment period described in Section 10965.3 shall inform
20 the applicant that he or she may be eligible for lower cost coverage
21 through the Exchange and shall inform the applicant of the
22 applicable enrollment period provided through the Exchange
23 described in Section 10965.3.

24 (b) On or before October 1, 2013, and annually *every October*
25 *I* thereafter, a health insurer shall issue a notice to a policyholder
26 enrolled in an individual health benefit plan offered outside the
27 Exchange. The notice shall inform the policyholder that he or she
28 may be eligible for lower cost coverage through the Exchange and
29 shall inform the policyholder of the applicable open enrollment
30 period provided through the Exchange described in Section
31 10965.3.

32 (c) This section shall not apply where the individual health
33 benefit plan described in subdivision (a) or (b) is a grandfathered
34 health plan.

35 10965.15. (a) On or before October 1, 2013, and annually
36 *every October I* thereafter, a health insurer shall issue the following
37 notice to all policyholders enrolled in an individual health benefit
38 plan that is a grandfathered health plan:
39

1 New improved health insurance options are available in
2 California. You currently have health insurance that is not required
3 to follow many of the new laws. For example, your policy may
4 not provide preventive health services without you having to pay
5 any cost sharing (copayments or coinsurance). Also your current
6 policy may be allowed to increase your rates based on your health
7 status while new policies cannot. You have the option to remain
8 in your current policy or switch to a new policy. Under the new
9 rules, a health insurance company cannot deny your application
10 based on any health conditions you may have. For more
11 information about your options, please contact the California
12 Health Benefit Exchange, the Office of Patient Advocate, your
13 policy representative; ~~or an insurance broker, or a health care~~
14 ~~navigator.~~ *broker.*

15
16 (b) Commencing October 1, 2013, a health insurer shall include
17 the notice described in subdivision (a) in any renewal material of
18 the individual grandfathered health plan and in any application for
19 dependent coverage under the individual grandfathered health
20 plan.

21 (c) A health insurer shall not advertise or market an individual
22 health benefit plan that is a grandfathered health plan for purposes
23 of enrolling a dependent of a policyholder into the plan for policy
24 years on or after January 1, 2014. Nothing in this subdivision shall
25 be construed to prohibit an individual enrolled in an individual
26 grandfathered health plan from adding a dependent to that plan to
27 the extent permitted by PPACA.

28 10965.16. Except as otherwise provided in this chapter, this
29 chapter shall be implemented to the extent that it meets or exceeds
30 the requirements set forth in PPACA.

31 *10965.17. (a) The commissioner may, no later than December*
32 *31, 2014, adopt emergency regulations implementing this chapter.*
33 *The commissioner may readopt any emergency regulation*
34 *authorized by this section that is the same as or substantially*
35 *equivalent to an emergency regulation previously adopted under*
36 *this section.*

37 *(b) The initial adoption of emergency regulations implementing*
38 *this chapter and the one readoption of emergency regulation*
39 *authorized by this section shall be deemed an emergency and*
40 *necessary for the immediate preservation of the public peace,*

1 health, safety, or general welfare. Initial emergency regulations
2 and the one readoption of emergency regulations authorized by
3 this section shall be exempt from review by the Office of
4 Administrative Law. The initial emergency regulations and the
5 one readoption of emergency regulations authorized by this section
6 shall be submitted to the Office of Administrative Law for filing
7 with the Secretary of State and each shall remain in effect for no
8 more than one year, by which time final regulations may be
9 adopted. The commissioner shall consult with the Director of the
10 Department of Managed Health Care prior to adopting any
11 regulations pursuant to this subdivision for the specific purpose
12 of ensuring, to the extent practical, that there is consistency of
13 regulations applicable to entities regulated by the commissioner
14 and those regulated by the Department of Managed Health Care.

15 ~~SEC. 19.~~

16 SEC. 20. (a) The Insurance Commissioner may adopt
17 regulations, to implement the changes made to the Insurance Code
18 by this act, pursuant to the Administrative Procedure Act (Chapter
19 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
20 Title 2 of the Government Code). The commissioner shall consult
21 with the Director of the Department of Managed Health Care prior
22 to adopting any regulations pursuant to this subdivision for the
23 specific purpose of ensuring, to the extent practical, that there is
24 consistency of regulations applicable to entities regulated by the
25 commissioner and those regulated by the Department of Managed
26 Health Care.

27 ~~(b) (1) The commissioner may adopt emergency regulations~~
28 ~~implementing the changes made to the Insurance Code by this act~~
29 ~~no later than December 31, 2014. The commissioner may readopt~~
30 ~~any emergency regulation authorized by this section that is the~~
31 ~~same as or substantially equivalent to an emergency regulation~~
32 ~~previously adopted under this section.~~

33 ~~(2) The initial adoption of emergency regulations implementing~~
34 ~~this section and the one readoption of emergency regulations~~
35 ~~authorized by this section shall be deemed an emergency and~~
36 ~~necessary for the immediate preservation of the public peace,~~
37 ~~health, safety, or general welfare. The initial emergency regulations~~
38 ~~and, notwithstanding Section 11346.1 of the Government Code,~~
39 ~~the one readoption of emergency regulations authorized by this~~
40 ~~section shall be submitted to the Office of Administrative Law for~~

1 ~~filing with the Secretary of State and each shall remain in effect~~
2 ~~for no more than 180 days, by which time final regulations may~~
3 ~~be adopted. The commissioner shall consult with the Director of~~
4 ~~the Department of Managed Health Care prior to adopting any~~
5 ~~regulations pursuant to this subdivision for the specific purpose~~
6 ~~of ensuring, to the extent practical, that there is consistency of~~
7 ~~regulations applicable to entities regulated by the commissioner~~
8 ~~and those regulated by the Department of Managed Health Care.~~

9 ~~SEC. 20.~~

10 *SEC. 21.* This bill shall become operative only if Senate Bill
11 2 of the 2013–14 First Extraordinary Session is enacted and
12 becomes effective.

O